

**MANAGED HEALTH CARE IMPROVEMENT TASK FORCE  
JUNE 20, 1997 REGULAR BUSINESS MEETING MINUTES**

Adopted by the Task Force on August 7, 1997.

---

**Friday June 20, 1997**

**10:00 A.M.**

**2550 Mariposa Mall - Assembly Room**

**[State Office Building]**

**Fresno, California**

**I. CALL TO ORDER [Chairman, Alain Enthoven, Ph.D.] - 10:00 A.M.**

The third business meeting of the Managed Health Care Improvement Task Force [Task Force] was called to order by Chairman, Dr. Alain Enthoven, at the State Office Building in Fresno, California.

**II. ROLL CALL AND DECLARATION OF A QUORUM - 10:02 A.M.**

Task Force Secretary, Ms. Jill McLaughlin, took roll. The following Task Force members declared they were present: Dr. Bernard Alpert, Ms. Rebecca Bowne, Ms. Barbara Decker, Dr. Alain Enthoven, Ms. Jeanne Finberg, Mr. Terry Hartshorn, Mr. William Hauck, Mr. Mark Hiepler, Dr. Michael Karpf, Mr. Clark Kerr, Mr. Peter Lee, Mr. John Perez, Mr. Anthony Rodgers, Dr. Helen Rodriguez-Trias, Ms. Ellen Severoni, Dr. Bruce Spurlock, Mr. Ronald Williams, Mr. Alan Zaremborg, and Mr. Steven Zatzkin.

The following Ex-Officio members were present: Ms. Kim Belshe', Mr. Keith Bishop, and Mr. David Knowles.

**III. OPENING REMARKS - 10:10 A.M.**

Chairman Enthoven began the meeting by announcing, that the day's program was about consumer protection as implemented by managed health care plans and would focus on two issues: the managed care environment around 1975 when the Knox-Keene Act was enacted, and a discussion of the Act's objectives and how it's been progressing; and then the second part would be a discussion on consumer involvement communication and information. Chairman Enthoven announced that forty-five minutes had been allocated for each topic.

#### **IV. REPORTS - 10:20 A.M**

##### **A. Presentations on Consumer Protection as Implemented by Managed Care Health Plans - Warren Barnes and Keith Bishop with the Department of Corporations.**

Mr. Warren Barnes and Mr. Keith Bishop, with the Department of Corporations [DOC], presented background information about the history of managed care regulation in California and about the Knox-Keene Act.

Mr. Barnes began by noting that concerns about changes in financial incentives run throughout the history of managed care in California. He described the origins of managed care (then known as prepaid care) during the 1930's in California; some of those early plans are still operating today. Mr. Barnes stated that in the 1960's, there was a resurgence of interest in managed care, with a number of new entrants into the market. The more established companies were concerned that problems with these new plans might tarnish the entire industry's image; they therefore sought legislation to regulate the managed care industry. The resulting legislation, the 1965 Knox-Mills Health Plan Act, provided for registration of health care service plans. The Attorney General administrated the Knox-Mills Act. Mr. Barnes noted that during the late 1960's, then-Governor Reagan encouraged the use of prepayment for delivery of medical services to the Medi-Cal population. The ensuing problems with marketing, quality of care, administration, etc., resulted in the Waxman-Duffy Health Plan Act of 1972. This Act gave the Department of Health Services formal authority to contract for Medi-Cal services on a prepaid basis and to monitor those contracts. Mr. Barnes stated that neither the Knox-Mills nor Waxman-Duffy Acts were able to contain the "entrepreneurial ferment" associated with prepaid health care, particularly for the Medi-Cal plans.

As a consequence, Mr. Barnes stated, the Legislature enacted the Knox-Keene Health Service Plan Act of 1975. Because the Attorney General no longer wanted to regulate managed care, the Legislature considered other options. Though the Department of Insurance [DOI] regulates managed care in many states, it was rejected in California on the grounds that managed care is primarily a service, not insurance, industry. The Department of Health Services [DHS] was rejected because of its role as a health services purchaser. Ultimately, the DOC was chosen for two reasons: it had a long history of successful regulation of a large variety of different types of businesses, and it had its own enforcement capability. Mr. Barnes summarized by saying that, in many respects, the regulatory emphasis has come full circle, transitioning from financial and to quality of care concerns.

Mr. Keith Bishop next summarized today's Knox-Keene Act [Act].

Mr. Bishop stated that the four main purposes of the Act were to ensure: 1) the continued role of the professional as the determiner of the patient's health care needs; 2) the best quality of care at the lowest cost by transferring financial risk from patients to providers; 3) the financial stability of plans; and 4) that enrollees receive available and accessible health care services, maintaining continuity of

care. He stated that the Act applies only to **health care service plans** which are characterized by prepayment or periodic charges for direct or contracted delivery of health care services. Mr. Bishop described the documentation requirements for licensing, the material modifications process, and standards for marketing, contracting, grievance processes, disclosures, and other business operations. Mr. Barnes emphasized that the Act has very specific licensing requirements in a wide variety of areas. Mr. Barnes went on to describe the oversight and enforcement authority granted by the Act. DOC conducts periodic and non-routine medical surveys and financial examinations. It also has the authority to issue cease and desist orders, institute civil injunctive actions, seek appointment of a receiver, seize the business, freeze new enrollment, and issue civil penalties. Mr. Bishop concluded by noting that the Act contains both specificity and broad principles and encouraged people who are considering regulation to become familiar with its operation, philosophy, and requirements.

Chairman Enthoven thanked Mr. Barnes and Mr. Bishop for their presentations. He reiterated that the Task Force members received a copy of the Knox-Keene Act and that he hoped that members have reviewed the document. A discussion on the following topics ensued: further details about implementation of the Act; DOC's recent budget augmentation; whether PPO and POS plans should be regulated by DOC or DOI; DOC and DHS regulatory overlap on quality issues; regulation of medical groups; physician compensation and financial pressure; streamlining auditing efforts between DHS, DOC, and the private sector; collection and tracking of complaint data; potential costs of outcomes evaluation; and the apparent incompatibility in the Act between transferring the assumption of financial risk to providers and requiring the delivery of care without the hindrance of financial concerns. A five minute recess was taken during this discussion.

#### **B. Presentations on Consumer Protection as Implemented by Managed Care Health Plans - Ellen Severoni, Executive Director of California Health Decisions.**

Ms. Severoni was called upon to discuss consumer information and involvement. Ms. Severoni presented information about the history of California Health Decisions and its mission of educating and involving the public on issues relevant to individual and societal health choices. She described five consistent areas of concern in health care; cost, waste/fraud/abuse, technology, aging, and values. Ms. Severoni next outlined the member advisory committee of the CalOPTIMA program in Orange County, emphasizing its central role in defining and carrying out the program's mission. She then discussed the consumer feedback loop that is a model for improving health care quality and that involves patients, providers, purchasers, and health plans in a consumer-driven process of research, solutions, change, and evaluation. Ms. Severoni described the findings of her work, including a joint project between Chevron, Health Net, and Hill Physicians Medical Group. Chairman Enthoven thanked Ms. Severoni on her insightful and interesting presentation.

**C. Presentations on Consumer Protection as Implemented by Managed Care Health Plans - Ms. Jeanne Finberg, Consumers Union** [Handouts of presentation are available]

Ms. Finberg began her presentation by describing the role of the Consumers Union and the findings of the research done regarding managed health care. Ms. Finberg spoke of a current project involving the Medi-Cal managed care program in California, working with the consumer representatives who are supposed to sit on advisory committees of both plans in each Two-Plan county. She is having difficulty identifying these representatives, either because the plans do not actually have any or because the plans will not release the representatives' names for confidentiality reasons. Ms. Finberg described the Consumers Union survey research, published in two issues of Consumer Reports, that presented comparisons of health plan quality. She discussed the limitations of HEDIS data as a basis for selecting a health plan. These limitations included inconsistent measurement methodology, inadequate data systems, high costs of participating in HEDIS and collecting the data, lack of benchmarks for appropriate utilization, and unwillingness of plans to report results due to adverse selection issues. She also identified a need for quality measures at the medical group and physician level. Ms. Finberg summarized that there is a need for standardization of information and more cooperation or required disclosure from the plans. Chairman Enthoven thanked Ms. Finberg for her presentation.

Ms. Estella Martinez of the CalOPTIMA program offered further testimony about member involvement with CalOPTIMA. Mr. Steve McDermott of Hill Physicians Medical Group spoke about his positive experiences with the consumer feedback loops and his organization's payment structures. Mr. Beau Carter of Integrated Healthcare Associations testified about creating enrollee-driven models that will increase the responsiveness, accountability, and performance of managed care.

A discussion on the following topics ensued: CalOPTIMA's progress in meeting its goals; the kinds of information that are most useful to consumers; incentives for primary care providers to see patients and communicate effectively; how to institutionalize consumer participation; distinctions between payment structures for plans, medical groups, and physicians; utilization and disease management in fee for service versus managed care systems; outcome data as a basis for comparing plans; whether patients are aware of or understand how their doctor is paid; the role of government versus market drivers; the need for a context for the large amounts of data about quality that are available.

Chairman Enthoven suggested he forego his summarization on the May 30<sup>th</sup> study session and the executive director's report and proceed to the New Business as reflected on the meeting agenda. Receiving no objection, Chairman Enthoven proceeded to New Business.

## **V. NEW BUSINESS - 11:30 A.M.**

### **A. Adoption of the May 8, 1997 minutes**

Chairman Enthoven asked for a motion to adopt the May 8<sup>th</sup>, 1997 Task Force business meeting minutes. Mr. Perez made the motion to adopt the minutes and it was seconded by Mr. Kerr. The motion to adopt the minutes was adopted unanimously.

### **B. Adoption of the amendments to the Task Force Bylaws and Standing Rules**

Chairman Enthoven stated that the next order of business was to adopt the amendments to the Task Force Bylaws and Standing Rules. He asked Ms. Alice Singh, Deputy Director of Legislation and Operations, to briefly discuss the proposed technical amendments prior to a motion being made.

Ms. Singh stated that the first proposed amendment authorized the Task Force Chairman to create expert resource groups and to appoint members thereto. The second proposed amendment authorized the Assembly Speaker and Senate Rules Committee to appoint ex-officio members to the Task Force. The third and final amendment was a technical clarification to address the issue of persons voting on behalf of Task Force members.

Several of the Task Force members raised questions regarding the ERGs and their abilities to meet and distribute draft documents to other Task Force members for review. Specifically, Dr. Spurlock asked staff to clarify whether ERGs are subject to the Open Meetings Act. Ms. Singh indicated that she and legal staff were developing ERG Guidelines to address these and other issues regarding ERGs and ERG protocols. The Guidelines would be forwarded to Task Force members in the next few weeks.

Mr. Perez suggested that the proposed amendment to the Bylaws affecting ERGs be amended to strike "of no more than two" as it related to the number of Task Force members allowed to serve on an ERG. This language was further clarified by Chairman Enthoven to state:

If an expert resource groups is comprised of more than two Task Force members, meetings of that expert resource group shall be publicly noticed pursuant to Government Code section 11120 et. seq., the Bagley-Keene Open Meeting Act.

Chairman Enthoven then moved to adopt the above language as an amendment to the Bylaws, and it was seconded by Mr. Hauck. The motion to amend this section of the Bylaws was unanimously adopted.

Mr. Hauck then spoke to the second amendment stating that by allowing the Senate and the Assembly to appoint ex officio members, thus adding more participants to the Task Force, would make the job of the Task Force more

difficult. Mr. Perez and Dr. Romero reminded members that the appointment authority was a technical amendment and that the Senate Rules Committee had already appointed two ex officio members. After much discussion, Mr. Lee suggested an amendment to state that the Assembly Speaker and the Senate Rules Committee may appoint no more than a combined number of five ex officio members [so that the Governor and the Legislature each had no more than five ex officio members on the Task Force]. This amendment was unanimously adopted.

Mr. Perez then asked the Chairman if he could address a few additional issues with respect to the Bylaws before the Task Force considered the adoption of the proposed amendment to the Standing Rules. Chairman Enthoven granted Mr. Perez the floor. Mr. Perez referenced page four, paragraph 1 of the Bylaws pertaining to the requirement that the Executive Director has final approval of documents before they are published or released or attributed. Mr. Perez did not find this to be an acceptable rule to govern the publication activities of a group this size, and asked to strike approval of the Executive Director and replace it with "approval of the Task Force". Mr. Lee suggested a friendly amendment to state that materials distributed by the Task Force shall be approved by, and insert "a majority vote of the Task Force or the Task Force Executive Director". Mr. Perez further clarified the wording in the next paragraph to state instead of using "exclusively", to insert the word "necessarily", so the disclaimer used with Task Force member writings [e.g., opinion/editorials] would read "views expressed herein aren't of the author and do not necessarily represent the view or opinions of the Managed Health Care Improvement Task Force". The motion to adopt the aforementioned amendments to the bylaws was moved by Mr. Perez, seconded by Mr. Rodgers and unanimously adopted.

Mr. Perez suggested one more amendment to the Bylaws with respect to items being placed on the Task Force meeting agenda. Specifically, Mr. Perez moved to adopt an amendment to allow Task Force members to place items on an agenda by a simple majority of the total authorized membership of the Task Force. Mr. Lee seconded this motion and it was unanimously adopted.

Ms. Singh announced that a vote was still needed to adopt the staff proposed amendment to the Standing Rules prohibiting any person from voting on behalf of a Task Force member. Mr. Lee made a motion to adopt the proposed amendment and it was seconded by Mr. Perez. The motion was adopted unanimously.

#### **IV. PUBLIC COMMENT - 1:15 P.M.**

Chairman Enthoven asked if any members of the audience would like to give their testimony, and the audience declined. Chairman Enthoven mentioned to the Task Force members that a list of 14 expert resource groups [ERG] had been developed and would be soon forwarded to the full Task Force for review. Dr. Romero mentioned that 14 groups will be a challenge to staff and that it may be appropriate to develop larger policy options work groups to encompass the work of several ERGs. Dr. Romero also asked each ERG to address the

following questions as they relate to their individual topic[s]: 1) What is the problem [real or perceived]? 2) What gaps or deficiencies exist in the market and/or state governing structure that may be causing, or failing to ameliorate, the problem? 3) What role should the various market participants [e.g., purchasers, plans, consumers, providers] and/or state government play in solving the problem? 4) Where there is a role for state government, how should state government be organized to best solve the problem?

**V. ADJOURNMENT - 1:30 P.M.**

Chairman Enthoven said that without objection, the study session would be adjourned. Seeing no objection, Chairman Enthoven declared that the July 11<sup>th</sup> Study Session was hereby adjourned.

---

**Notes:**

Information regarding Managed Health Care Improvement Task Force meetings may be obtained by writing the Task Force Administrative Assistant, Ms. Florence Neff, at 1400 Tenth Street, Room 206, Sacramento, California 95814 or calling (916) 324-1711.